



STATE OF VERMONT  
DEPARTMENT OF LABOR & INDUSTRY  
WORKERS COMPENSATION DIVISION  
5 GREEN MOUNTAIN DRIVE, PO BOX 488  
MONTPELIER, VT 05601-0488  
(802) 828-2286

Form 25M

Rev 8/07

State File No.:

Insurance Co. File No.:

Date of Injury:

[www.labor.vermont.gov](http://www.labor.vermont.gov)

This form shall be filed whenever a claimant is eligible to receive more than 90 calendar days of continuous temporary total disability benefits (see Rule 53.1100). Failure to file this form promptly and accurately may result in administrative sanctions pursuant to Rule 45.000.

## MEMORANDUM OF PAYMENT

### Employee

Last Name:

First Name:

Mailing Address

City

State

Zip

Telephone Number

### Employer

Employer Name

Employer Telephone Number

Insurer

### Payment Made

Weekly Compensation

Date Disability Payment Began:

Weekly Amount Paid:

Total Amount of Indemnity Paid To Date:

Other: (Please Explain)

### ISSUED BY:

Carrier:

Administrator (if not carrier):

Adjuster Name:

Telephone No.

Adjuster Signature:

Adjuster's Employer:

Adjuster License #:

Company Responsible for Payment:

Mailing Address

City

State

Zip